

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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05638  
MAY 1962  
MAY 1962  
05633

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Spikesville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Orbitus</u>			
c. LENGTH OF STAY IN TB <u>1 1/2 years</u>				d. STREET ADDRESS <u>5552 Dolores Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNIE GRACE BIDGOOD</u>				4. DATE OF DEATH <u>May 4 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1879</u>	
9. AGE (In years, last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas A. Bidgood</u>				14. MOTHER'S MAIDEN NAME <u>Ella T. March</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Michael C. Bidgood</u>				Address <u>as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Cardiac failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1961</u> <u>70</u> <u>5-4-62</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>5-4-62</u> , to <u>5-4-62</u> , that (I) (we) last saw the deceased alive on <u>5-4-62</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-5-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				22d. ADDRESS <u>SPICESVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Churchland Baptist</u>		23d. LOCATION (City, town or county) (State) <u>Churchland, Sta.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Haight</u> ADDRESS <u>Spikesville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DUL

(503)

M

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Very truly  
yours  
J. M. Smith

10000

10000

10000

10000

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05639

## CERTIFICATE OF DEATH

05634

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN IB <b>21 yrs. 5 mos. 13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>18 1/2 N. Lee St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Theodore</b> Last <b>Bolyard</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1904</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months <b>57</b> Days <b>12</b> Hours <b>10</b> Min. <b>PM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Millard Bolyard</b>				14. MOTHER'S MAIDEN NAME <b>-</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address <b>-</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung, terminal phase</b> DUE TO (b) <b>163X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Schizophrenic reaction, catatonic type.</b> DUE TO (c) <b>Schizophrenic reaction, catatonic type.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, tectory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 9, 1960</b> to <b>May 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 22, 1962</b> , and that death occurred at <b>12:10 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Adnan Sonmez, M.D.</b>				22b. DATE SIGNED <b>5/22/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Adnan Sonmez, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Elk Garden, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				25a. REC'D BY REGISTRAR <b>MAY 25 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05640

05635

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROUTE 4</u>		d. STREET ADDRESS <u>R 4</u>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>MAYS</u> Last <u>BOND</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 28-1909</u>
9. AGE (In years, lost birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRANS Supt</u>		12. KIND OF BUSINESS OR INDUSTRY <u>READY MIXED CONCRETE</u>	
13. FATHER'S NAME <u>THOMAS B BOND</u>		14. MOTHER'S MAIDEN NAME <u>JANE MAYS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>220-05-9411</u>	
17. ADDRESS <u>163X ROUTE 4 WESTMINSTER MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRACHED-ESOPHAGEAL FISTULA</u> DUE TO (b) <u>CARCINOMA OF LUNG</u> DUE TO (c) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 6</u> , 19 <u>62</u> , to <u>MAY 19</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>MAY 18</u> , 19 <u>62</u> , and that death occurred at <u>1:35</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>JAMES T. MARSH</u> M.D.		DATE SIGNED <u>5/19/62</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		ADDRESS (Street, city or town, state) <u>1050 MAIN ST WESTMINSTER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-22-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jessop Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, TOWSON</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			





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VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05641

05636

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY in 1b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>707 Rossmore Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Eva Louise Bonifant</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>May 21 19 62</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1879</b>
<b>9. AGE</b> (In years last birthday) <b>82 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>John Gittings</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Maggie</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> <b>Springfield Hospital Records</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic gangrene, right leg</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerosis and Diabetes</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. associated with cerebral arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>May 3, 19 62 to May 21, 19 62</b>
<b>21. I certify that (I) (this hospital) attended the deceased from May 3, 19 62 to May 21, 19 62, that (I) (we) last saw the deceased alive on May 21, 19 62, and that death occurred at 11 p.m. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Agustin del Campo</b> M.D.		<b>22b. DATE SIGNED</b> <b>5-22-62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Agustin del Campo, M.D.</b>		<b>22d. ADDRESS</b> <b>Springfield State Hospital, Sykesville, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>May 24, 1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>George Washington Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Prince George's County, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Arthur G. Hines</b>		<b>25a. WITTED BY REGISTRAR</b> <b>May 24 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>

## HEALTH

535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05642					05637					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY			
Carroll		MARYLAND			Maryland		Carroll			
Rural--Woodbine		life			X Rural-- Woodbine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
R. D. 1-- Near Winfield					R. D. 1--Near Winfield					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
ROBERT W. BOWER					MAY 24 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White				June 18, 1912		49 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer					Farming		Maryland		U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Thomas M. Bower					Eva Conaway					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No							Mrs. Tresa C. Bower, Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular Accident</u>										
342X DUE TO (b) <u>Brain abscess</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Meningitis</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19										
21. I certify that (I) (this hospital) attended the deceased from <u>5/22/62</u> , 19 <u>62</u> , to <u>5/24</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>62</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE			22c. PHYSICIAN'S NAME (Type)		
<u>Julius Chapko</u>					M.D.			5/26/62		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Julius Chapko, M. D.					854 W. Green St., Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial		5-26-1962		Lakeview Mem. Gardens			Carroll Co., Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. M. Waltz, Box 241--Sykesville, Md.					MAY 28 '62		C. M. Waltz			



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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Bureau" and "Division" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05643

## CERTIFICATE OF DEATH

05638

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>8</u> <u>das.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>70 Madison St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Rydie</u> Middle <u>Lee S.</u> Last <u>BROWN</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>26</u> Year <u>1962</u>	
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>SEPARATED</u> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-15-86</u>
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Howard Spalding</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Hattie Nichols</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Springfield State Hosp. Records - Sykesville, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction due to</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion.</u> (c) <u>Arteriosclerotic heart disease.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoneurotic Disorder, Depressive reaction.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-18-60</u> , <b>19</b> , <b>to</b> <u>5-26-62</u> , <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>5-26-62</u> , <b>19</b> , <b>and that death occurred at</b> <u>1:05 a.m.</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Agustin del Campo</u> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>	<b>22b. DATE SIGNED</b> <u>5/26/62</u>
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Agustin del Campo, M.D.</u>		<b>22d. ADDRESS</b> <u>Sykesville, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>5/29/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rest Haven Funeral Chapel</u> <u>Wm. G. Horst</u>		<b>ADDRESS</b> <u>Hagerstown, Md.</u>	<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAY 31 '62</u>
		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

05639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hannover</u> 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Adams (males only)</u>		d. STREET ADDRESS <u>327 N. Franklin St</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Louise</u> First Middle Last		4. DATE OF DEATH <u>May 31</u> 19 <u>62</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1889</u> 72 years
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
10a. BIRTHPLACE (State or foreign country) <u>Adams Co Pa</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>Joseph Joel</u>		13. MOTHER'S MAIDEN NAME <u>Annie King</u>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>None</u>	
16. INFORMANT <u>Stirling Helwig, 260 W. Hannover St</u>		17. ADDRESS <u>Hannover Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arterio Sclerosis (Genl)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>May 31</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>62</u> , and that death occurred at <u>10:10 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Glenn Feichter</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE <u>6/1/62</u>	
PHYSICIAN'S NAME (Type)		DATE	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Hannover Pa York Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher</u>		24a. REC'D BY REGISTRAR <u>June 5 '62</u>	
ADDRESS <u>Hannover Pa</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

WASH DC

CERTIFICATE OF DEATH

(M)

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical history.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05645 Item 1c Film G315 6/28/62 jwk											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5901 Sonoma Road</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN <u>MD</u> <u>Since Dec. 29, 1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				First Middle Last <u>Florence Elgin Clark</u>				4. DATE OF DEATH Month Day Year <u>5 29 1962</u>			
3. NAME OF DECEASED (Type or print)		5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-88</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Louise Clark</u>				14. MOTHER'S MAIDEN NAME <u>Jenny Leibensperg</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>287-05-0993</u>				17. INFORMANT <u>Records of Springfield St. Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardiac failure</u> (c) <u>Arteriosclerosis general</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>C.B.S. with cerebral arteriosclerosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 29, 1962</u> to <u>May 29, 1962</u> that (I) (we) last saw the deceased alive on <u>May 29, 1962</u> , and that death occurred at <u>9 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Myron Nizankowsky</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>5-30-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Myron Nizankowsky</u>				22d. ADDRESS <u>Springfield St. Hosp. Sykesville Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<u>Burial-Transit</u>		<u>5/31/62</u>		<u>Grove Hill Cemetery</u>				<u>Oil City, Pennsylvania</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>				25a. REGISTRAR'S SIGNATURE <u>John S. Huns</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Huns</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05646						05641					
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>9mos. 7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clear Spring</b> d. STREET ADDRESS <b>R#1</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lola May Thomas Davis</b>						4. DATE OF DEATH Month Day Year <b>May 17, 1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 27, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Elmer Carlton Thomas</b>						14. MOTHER'S MAIDEN NAME <b>Cellie - LINE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterisclerotic Heart Disease.</b> <b>420.0</b> DUE TO <b>Generalized arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. with senile brain disease with psychotic reaction. Terminal Bronchopneumonia.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>August 10, 1961</b> , to <b>May 17, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1962</b> , and that death occurred at <b>2:18 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Agustin del Campo</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/17/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>						22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>5-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro CEMETERY</b>		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bert Funeral Home Boonsboro MD.</b>						25a. REC'D BY REGISTRAR <b>MAY 22 '62</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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Examination

Examination of the body

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John, W. J.

Examination

Examination of the body

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05647

05642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1mo. 5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u>		d. STREET ADDRESS <u>14 E. Overlea Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Deluca</u> Last <u>Deluca</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 2, 1877</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		IF UNDER 1 YEAR Months <u>84</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>	
13. FATHER'S NAME <u>Leopold Deluca</u>		14. MOTHER'S MAIDEN NAME <u>MARY Concetta Caruso</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-0251A</u>	
17. INFORMANT <u>Springfield Hospital Records.</u>		Address <u>Springfield Hospital Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 442x DUE TO (b) <u>Arterio Sclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with circ. dist., with psychotic reaction.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unknown; was found unable to walk; x-ray revealed fracture neck of femur, left.</u>	
20c. TIME OF INJURY Hour <u>10:30</u> a.m. <u>4/21/19 62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) <u>Sykesville</u> (County) <u>Carroll</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		DATE SIGNED <u>5/2/62</u>	
EXAMINER'S NAME (Type) <u>W. GLENN SPEICHER Acting</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/5/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc</u>		ADDRESS <u>5305 HARFORD Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAY 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____	
CITY _____		COUNTY _____		STATE _____	

(M)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05648 CERTIFICATE OF DEATH 05643													
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Frederick</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Sykesville</u>				c. LENGTH OF STAY IN 1b <u>4 YR. 11 MO. 14 D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> <u>1011-2</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>						d. STREET ADDRESS <u>116 EAST 3<sup>RD</sup> ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Violet</u> Last <u>Edmonds</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1962</u>										
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-83</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>RUFUS A. RAGGER</u>						14. MOTHER'S MAIDEN NAME <u>SUSAN BOYER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Springfield Hospital records, Sykes, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>715X</u> DUE TO <u>CARDIAC FAILURE. INFECTED LARGE RED SORE.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>C.B.S. ASSO. WITH JUVILE BRAIN DISEASE, WITH PSYCHOTIC REACTION.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>DAYS.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20c. TIME OF INJURY Hour e.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 26, 1961</u> to <u>MAY 12, 1962</u> that (I) (we) last saw the deceased alive on <u>MAY 12, 1962</u> and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Naci N. Buyukunfal</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MAY 12, 1962</u>					
22c. PHYSICIAN'S NAME (Type) <u>NACI N. BUYUKUNFAL</u>						22d. ADDRESS <u>Springfield State Hospital Sykesville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-15-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey and Son</u>						ADDRESS <u>Frederick, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
CERTIFICATE OF DEATH

1900

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(1)

NAME OF DECEASED  
AND PLACE OF BIRTH

Robert L. Bailey and Son Frederick, Maryland  
No. 1111  
No. 1111  
No. 1111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
c. LENGTH OF STAY IN 1b <b>46y. 11m. 6d.</b>					d. STREET ADDRESS <b>1940 Lemmon Street</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Helen</b>			First <b>Eisler</b>		Last <b>Eisler</b>		4. DATE OF DEATH Month <b>5</b>		Day <b>27</b>
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown</b>		9. AGE (In years last birthday) <b>81?</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>Hungary</b>		IF UNDER 1 YEAR Months <b>5</b>	
13. FATHER'S NAME <b>Brichta?</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Springfield Hospital records - Sykesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 300.7 Conditions, if any, which gave rise to immediate cause (b) <b>300.7</b> (e), stating the underlying cause last. (c) <b>300.7</b> DUE TO (b) <b>300.7</b> DUE TO (c) <b>300.7</b>								INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Schizophrenic reaction, other and unspecified.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Baltimore</b>	
20h. (State) <b>Maryland</b>		20i. (City or town) <b>Baltimore</b>		20j. (County) <b>Baltimore</b>		20k. (State) <b>Maryland</b>		20l. (City or town) <b>Baltimore</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/21/1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5/27/1962</b> , and that death occurred at <b>12:20 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Naci N. Buyukunsal, M. D.</b>					22b. DATE <b>5/27/62</b>				
22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 30/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom</b>		23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		23e. (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson &amp; Bros Inc 6010 Reisterstown Rd</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 31 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05650

CERTIFICATE OF DEATH

05645

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>127 E. Green St.</u>		d. STREET ADDRESS <u>802 Belgian Avenue</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>(M<sup>First</sup>ELLA FIELD<sup>Middle</sup>)</u> Last <u>FIELD</u>		<b>4. DATE OF DEATH</b> Month <u>MAY</u> Day <u>28</u> Year <u>1962</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>SEPT. 19, 1871</u>
<b>9. AGE</b> (In years last birthday) <u>90</u> yrs		<b>10. UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife at Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Maryland</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Hanson H. Keys</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Williams</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> <u>M<sup>s</sup> J. Elmer Mauller</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (general)</u> DUE TO (c)	
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 yrs +</u>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 yrs +</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <u>Nov 5, 1959</u> to <u>May 28, 1962</u> that I last saw the deceased alive on <u>May 27, 1962</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>W. Lenn Speicher</u> M.D.		<b>DATE SIGNED</b> <u>5/28/62</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Westminster Md</u>		<b>ADDRESS</b> (Street, city or town, state)	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>5/30/62</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GREENMOUNT CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>MAY 31 1962</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. Lenn Speicher</u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>W. Lenn Speicher</u>	

ACCOUNT FORM

1930

CERTIFICATE OF DEATH

1930

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05651 CERTIFICATE OF DEATH 05646

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN b. <b>6mo. 29days.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6</b> d. STREET ADDRESS <b>6602 Fairdel Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Leona</b> Middle <b>Rita</b> Last <b>Fitch</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>3</b> Year <b>1962</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan 26 1915</b>		<b>9. AGE (In years last birthday)</b> <b>47</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>17</b>		<b>11. IF UNDER 24 HRS.</b> Hours <b>15</b> Min. <b>47</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Feliz Gabriel</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Susanna Stephens</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war dates of service) <b>None</b>				<b>16. SOCIAL SECURITY NO.</b> <b>213-14-2801</b>				<b>17. INFORMANT</b> <b>Springfield Hospital Records</b>				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicopyemia</b> 455X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gangrenous bedsores</b> (e), stating the underlying cause last. DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Weeks</b> <b>Weeks</b>			
<b>2. MEDICAL CERTIFICATION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. due to epidemic encephalitis.</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 10-31-1961 to 5-3-1962, that (I) (we) last saw the deceased alive on 5-3-1962, and that death occurred 10:00 P.M. from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>Agustin del Campo</b> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>5-3-62</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Agustin del Campo, M.D.</b>						<b>22d. ADDRESS</b> <b>Springfield State Hospital, Sykesville, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>5/7/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn</b>				<b>23d. LOCATION (City, town or county)</b> <b>Baltimore - Md</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Carl B. Belcher</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 8 '62</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Finner</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05652  
05647

Item 8 Film G313 5/23/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Harold</b> Last <b>Francis</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b> <b>Nov. 5, 1883</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b>	IF UNDER 24 HRS. Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horticulturist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Liverpool, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wallace F. Francis</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Green</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>077-15-6483</b>		17. INFORMANT <b>Mrs. Dencil E. Laird R#1, Taneytown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Arteriosclerosis Generalized</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Four Sec.</b> <b>1 year</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 16, 1957</b> to <b>5/18, 1962</b> ; that (I) (we) last saw the deceased alive on <b>May 4, 1962</b> , and that death occurred at <b>5A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>E. Ambler Thompson</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/18/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>				22d. ADDRESS <b>Taneytown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/22/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Milford Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Milford, Connecticut</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Skiles</b> <b>C.O. Fuss &amp; Son</b>				ADDRESS <b>Taneytown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 21 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

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TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

05653

05648

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>10 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WINFIELD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>54 LIBERTY ST.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>B.</b> Last <b>FRANKLIN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>31</b> Year <b>1962</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 23-1888</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES FRANKLIN</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE FARVER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS ADALENE SCHAEFFER</b>		Address <b>WESTMINSTER MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis (genl)</b> (c) <b>several yrs</b> DUE TO <b>cause last.</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 28, 1962</b> to <b>May 31, 1962</b> that (I) (we) last saw the deceased alive on <b>May 31, 1962</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W Glenn Speicher</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/31/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>W GLENN SPEICHER</b>				22d. ADDRESS <b>Westminster Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/2/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		23d. LOCATION (City, town or county) (State) <b>WINFIELD MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DD. Harbler &amp; Sons</b>				ADDRESS <b>NEW WINDSOR MD</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 4 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shippensburg #3 md</u>				c. LENGTH OF STAY IN 1b <u>11 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bleu Mill Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE LACKEY GASSMAN SR.</u> First Middle Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10 1879</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harrisonburg, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Gassman</u>				14. MOTHER'S MAIDEN NAME <u>Ella Paul</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <u>220-34-5506</u>		INFORMANT <u>Ger. L. Gassman Jr. Westminster, Md.</u>		Address <u>Myrtle Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X</u> DUE TO <u>Parkinson's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>12 yrs</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>62</u> , to <u>May 8</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>62</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>15 Kemper Ave. Westminster, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>				DATE SIGNED <u>5/8/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook Cemetery Rural Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminster, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

I, the undersigned, being a duly qualified Medical Officer of Health for the District of \_\_\_\_\_, do hereby certify that \_\_\_\_\_ was born on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_ in the County of \_\_\_\_\_ and State of \_\_\_\_\_ and that he died on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_ in the County of \_\_\_\_\_ and State of \_\_\_\_\_ and that the cause of death was \_\_\_\_\_ and that the death was due to natural causes.

Witness my hand and the seal of the District of \_\_\_\_\_ at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_.

\_\_\_\_\_  
Medical Officer of Health

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenelg</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Franklin</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>13</b> Days <b>X</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stewart W. Gray</b>		14. MOTHER'S MAIDEN NAME <b>Maria -</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Thrombosis of the posterior left coronary artery.</b> DUE TO (c) <b>Aspiration Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Hours</b> <b>Days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 16, 1962</b> to <b>May 15, 1962</b> that (I) (we) last saw the deceased alive on <b>May 14, 1962</b> , and that death occurred at <b>5:45AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Adnan Sonmez</b> M.D.		22b. DATE SIGNED <b>5/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Adnan Sonmez, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 18, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b>	23d. LOCATION (City, town or county) (State) <b>Laytonsville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis K. Barber</b> ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 21 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05651

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2y. 4m. 22d.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401.4</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>? High Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Julia</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>5</b> Day <b>15</b> Year <b>19 62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/95</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Zack Owens</b>	
14. MOTHER'S MAIDEN NAME <b>Quade</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Springfield Hospital records - Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntary Psychotic Reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/23</b> <b>1959</b> to <b>5/15/</b> <b>1962</b> , that <b>no</b> (we) lost saw the deceased alive on <b>5/15/</b> <b>1962</b> , and that death occurred at <b>3:50 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Konstantin Weber</b> M.D.		22b. DATE <b>5/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/18/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	23d. LOCATION (City, town, or county) (State) <b>Bushwood Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingly, Towardtown, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 21 1962</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05657

05652

FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Eldersburg</b>		c. LENGTH OF STAY IN lb <b>1 1/2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Eldersburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10 Rolling View Drive</b>				d. STREET ADDRESS <b>10 Rolling View Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. Oscar</b>		First <b>M</b> Middle <b>Hackley</b>		Last <b>Hackley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1902</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of last year, or if retired) <b>Retired Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Locke Insulating Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Hackley</b>				14. MOTHER'S MAIDEN NAME <b>Jesse L. Kraut</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-3092</b>		17. INFORMANT Address <b>10 Rolling View Dr. Mrs. Adelaide A. Hackley, R.F.D. Box 313, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>420.1</b> DUE TO (e), stating the underlying cause last. <b>420.1</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Baltimore 27, Maryland</b>							
ACTUAL SIGNATURE <b>James I. Marsh</b>		NAME (Type) <b>JAMES I. MARSH</b>		DATE SIGNED <b>5/19/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore 27, Maryland</b>	
23. FUNERAL DIRECTOR <b>Spring Bypers</b>		ADDRESS <b>8728 Liberty Road Randallstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 23 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
05658					05653									
CERTIFICATE OF DEATH														
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION MILLS</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERAL MONTHS 27 WESTMINSTER</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW VIEW CONVALESCENT</u>					d. STREET ADDRESS <u>6 ANCHOR ST.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>HARRY WARNER HANDLEY</u>					4. DATE OF DEATH <u>MAY 16 1962</u>		Month Day Year							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 1 1885</u>		9. AGE (In years last birthday) <u>77</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TARIFF CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSOLIDATION COAL CO.</u>		11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB H. HANDLEY</u>					14. MOTHER'S MAIDEN NAME <u>ANNA M. WARNER</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>056-07-1469</u>					INFORMANT Address <u>SAME</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>10+ yrs</u> (c) <u>Had a stroke 2 1/2 yrs ago</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a stroke 2 1/2 yrs ago</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that I attended the deceased from <u>June 1952</u> to <u>May 16, 1962</u> that I last saw the deceased alive on <u>May 15, 1962</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>15 Kemper Ave Westminister Md</u>				
ACTUAL SIGNATURE <u>Reese Wilkens</u>					DATE SIGNED <u>5/14/62</u>									
PHYSICIAN'S NAME (Type) <u>DR E. REESE WILKENS</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>5/19/62</u>					22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY RURAL, WESTMINSTER, MD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>					ADDRESS <u>Westminister Md</u>					24a. REC'D BY REGISTRAR <u>Arthur S. House</u>				
										24b. REGISTRAR'S SIGNATURE				
										DATE <u>MAY 21 '62</u>				

1953

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CERTIFICATE OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05659

## CERTIFICATE OF DEATH

05654

1. PLACE OF DEATH a. COUNTY <u>Cornwall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cornwall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers (Rural)</u>	
c. LENGTH OF STAY IN b. <u>3 days</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cornwall County General Hospital Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE M. HARPER</u>		4. DATE OF DEATH <u>May 4 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-93</u>
9. AGE (In years, last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Smith</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Vance</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Paul Harper - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 yrs</u> <u>10 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>N.Y.</u> <u>1951</u> , to <u>May 4</u> , 1962, that (I) (we) last saw the deceased alive on <u>May 3</u> , 1962, and that death occurred at <u>10</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foard</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>		22b. DATE SIGNED <u>5/4/62</u>	
22d. ADDRESS <u>Manchester Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		23d. LOCATION (City, town or county) (State) <u>Cornwall Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hipton-Elise - Hampstead Md</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>MAY 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

10804

02328



Revised Sheet

Revised Sheet

No Paul Harper, Thompson's Hill

No

Will Howard

Will Howard

Will Howard - Thompson's Hill



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 8 & 9 Film G314 6/1/62 mh

05660

05655

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>14 days</b>				d. STREET ADDRESS <b>8500 - 16th Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice - Kahn</b>				4. DATE OF DEATH Month Day Year <b>May 10, 1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1897</b>	
9. AGE (In years last birthday) <b>1896</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>526X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Bronchiectasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. associated with cerebral arteriosclerosis, with psychosis.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-26-1962</b> , to <b>5-10-1962</b> , that (I) (we) last saw the deceased alive on <b>5-10-62</b> , and that death occurred <b>11:50 p.m.</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-11-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 13, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick S. ...</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 14 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Carroll Co. Gen. Hospital</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
c. LENGTH OF STAY IN 1b <b>8 HOURS</b>		d. STREET ADDRESS <b>56 Charles St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Co. General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>LOVIE</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>10</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MAY 23 - 1927</b>	
<b>9. AGE</b> (In years last birthday) <b>34</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>34</b> Days <b>10</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>CLARENCE HILL</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>VIRGIE JACKSON</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-20-8438</b>	
<b>17. INFORMANT</b> <b>THOMAS KEY SR</b>		<b>Address</b> <b>WESTMINSTER</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Amniotic fluid embolism</b> <b>648.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Recent Pregnancy</b> DUE TO (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>Rudiger Breiteneker</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <b>Rudiger Breiteneker, M.D.</b>		<b>DATE SIGNED</b> <b>May 11, 1962</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>5/13/62</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MT OLIVE</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>FREDERICK CO MD</b>	
<b>23. FUNERAL DIRECTOR</b> <b>D D Hartley &amp; Sons</b>		<b>24a. REC'D BY REGISTRAR</b> <b>MAY 14 '62</b>	
<b>ADDRESS</b> <b>New Windsor</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>26 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESTELLA</b> Middle <b>MAY</b> Last <b>KROH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 11, 1883</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EPHRAIM BACHMAN</b>		14. MOTHER'S MAIDEN NAME <b>CORNELIA WENTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>DAUGHTER - CORNELIA KROH 41 WESTMORELAND ST.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF LEFT BREAST</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1958</b> to <b>MAY 18, 1962</b> that I last saw the deceased alive on <b>MAY 18, 1962</b> and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Lewis Stewart, M.D.</b>		ADDRESS (Street, city or town, state) <b>19 RIDGE RD</b> DATE SIGNED <b>5/18/62</b>	
PHYSICIAN'S NAME (Type) <b>WESTMINSTER, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/21/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John L. Miller Cemetery, Rural Westminster, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr., Westminster, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 22 '62</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>C. H. &amp; H. H. H.</b>	

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VS A15 (4)  
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Blank lined paper with faint horizontal lines and a vertical margin line on the right. The paper shows signs of aging and has two dark circular marks on the right edge.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 7/61

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4yrs. 2mos. 4dys.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1128 Chesthaven Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Lillian</b> Last <b>Lewis</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>November 21, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan De-Lavergene- DeLaVergne</b>		14. MOTHER'S MAIDEN NAME <b>Anna C. -Claudine Thomson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No - none</b>		16. SOCIAL SECURITY NO. <b>- none</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bilateral lobular pneumonia, type undetermined.</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1958</b> , to <b>May 14, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1962</b> , and that death occurred at <b>10 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE SIGNED <b>5-14-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-18-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Zisk</b> <b>Warner E. Pumphrey, Inc., Silver Spring, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 17 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05664

## CERTIFICATE OF DEATH

05659

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linebors</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linebors (Rural)</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN - T - LOVELL</u> First Middle Last		4. DATE OF DEATH <u>May 31</u> 19 <u>62</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 - 1888</u> 73 yrs. Month Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas W Lovell</u>		14. MOTHER'S MAIDEN NAME <u>Emma McLouell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17-22-1530</u>	
17. INFORMANT <u>Mrs Minnie E Lovell - Linebors Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> 19 <u>62</u> , to <u>May 31</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 30</u> 19 <u>62</u> , and that death occurred at <u>4</u> a.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. Porterfield</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 1/62</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Linebors</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Elmh</u>		25a. REC'D BY REGISTRAR <u>JUN 4 '62</u>	
ADDRESS <u>Hampstead Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Haines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05665				05660									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY in 1b <b>21 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>409 Park Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>James</b> Last <b>Martin, Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>19 62</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 23, 1889</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Hugh J. Martin, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Keefer</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 1918-1919- Army #3074877</b>				16. SOCIAL SECURITY NO. <b>578-05-7232A</b>				17. INFORMANT <b>Springfield Hospital Records.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 331X DUE TO <b>C.V.A. with complete paralysis of the left side</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1962</b> to <b>May 31, 1962</b> that (I) (we) last saw the deceased alive on <b>May 30, 1962</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Adnan Sonmez, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>5/31/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>Adnan Sonmez, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-4-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Indeville Ave, Balt. Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight Sykesville, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>4 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>05666</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05661</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b> c. LENGTH OF STAY IN 1b <b>RFD # 2</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RFD # 2</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b> d. STREET ADDRESS <b>RFD # 2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Daniel</b> Middle <b>Eugene</b> Last <b>Mayne</b>						<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>17</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 30, 1956</b>		<b>9. AGE (In years last birthday)</b> <b>5</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>17</b> Hours <b>17</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Frederick, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert M. Mayne</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Shirley A. Cooley</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Mrs Robert M. Mayne, Item 2</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broken neck</b> <b>835x</b> DUE TO <b>Tractor accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Tractor accident</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Nil</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor upset on him</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>9</b> Hour a.m. <b>5/17</b> 19 <b>62</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.) <b>Farm Rr Mt Airy Carroll Md</b>		<b>20f. (City or town) (County) (State)</b>			
<b>1. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>JAMES T. MARSH</b> <b>EXAMINER'S NAME (Type)</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>May 20, 1962</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Jennings Chapel</b>		<b>22d. LOCATION (City, town, or country) (State)</b> <b>Florence, Md.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>Olin L. Molisworth</b>						<b>ADDRESS</b> <b>Damascus, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 21 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Marsh</b>	

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(M)

Handwritten notes and signatures, including "X" marks and "p-310" written vertically.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

<div> <div> <div>1</div> <div>05667</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05662</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u> c. LENGTH OF STAY IN 1b <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution, residence before admission) a. <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALFRED - S - MAYS</u> First Middle Last						<b>4. DATE OF DEATH</b> <u>May 4 1962</u> Month Day Year					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-1-1888</u> Yrs. Months Days		<b>9. AGE</b> (In years, if UNDER 1 YEAR, if UNDER 24 HRS.) <u>73</u> yrs. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Abraham Mays</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Shearer</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give year or date of service)				<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Mrs. Blanch Mays Manchester Md</u> Address _____					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>min</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted gunshot.</u>							
<b>20c. TIME OF INJURY</b> <u>5:14</u> a.m. <u>5/4</u> 19 <u>62</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Manchester</u> (County) <u>Carroll</u> (State) <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u> <b>EXAMINER'S NAME</b> (Type) <u>JAMES T. MARSH</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>May 7-62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Peter's</u>		<b>22d. LOCATION</b> (City, town, or country) <u>Balto Co</u> (State) <u>Md</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Hipton-Clive</u> ADDRESS <u>Hampstead Md</u>						<b>24a. REC'D BY REGISTRAR</b> <u>MAY 7 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Robert L. Hines</u>			

RECEIVED  
MEDICAL TREATMENT  
HOSPITAL  
1953

FOR FILE  
HOSPITAL

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Blank page with faint horizontal lines and circular stamps.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

05668

05663

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIST</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GIST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. R.D. 3 Sykesville</u>		d. STREET ADDRESS <u>P.O. Sykesville. R.D. 3</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas L. McKENZIE</u>		4. DATE OF DEATH Month Day Year <u>5-9-62</u> 19	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 6, 1874</u> 87 yrs.
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw Mill Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ZACARIAH McKENZIE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DURST</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT Address <u>Mr. GRANT H. McKENZIE, Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (chronic)</u> DUE TO <u>592X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis (chronic)</u> DUE TO <u>Flu</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>Few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5-8-62</u> , 19 <u>59</u> , to <u>May 9-12-62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>5-8-62</u> , 19 <u>62</u> , and that death occurred at <u>7:15</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. JENNETT</u> M.D.		ADDRESS (Street, city or town, State) <u>103 E. Main Westminster Md.</u> DATE SIGNED <u>5-10-62</u>	
PHYSICIAN'S NAME (Type) <u>W.C. JENNETT M.D.</u>		<u>103 E. MAIN WESTMINSTER MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May-12, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Anns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aviton, Garrett Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Box 241 Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>William L. Kirsch</u>			

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05669

05664

1. PLACE OF DEATH a. COUNTY <b>Balti Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> <b>Carroll</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>2044 York Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Elsworth Merryman, Sr.</b>			4. DATE OF DEATH Month Day Year <b>May 8, 1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1899</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Radio Broadcastin</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Lewis Elsworth Merryman</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Williams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>215-03-9326</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute peritonitis</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Perforated gastric ulcers</b> (c) <b>Carcinoma of the right lung with metastasis to the third thoracic vertebra.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to arteriosclerosis.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Weeks</b> <b>Months.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 20, 1962</b> to <b>May 8, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1962</b> , and that death occurred at <b>10 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Adnan Sonmez</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/8/62</b>
22c. PHYSICIAN'S NAME (Type) <b>Adnan Sonmez, M.D.</b>			22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Catholic</b>		23d. LOCATION (City, town or county) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Inc., Towson, Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 14 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

2225

23279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BALTIMORE STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05665

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE RURAL</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ULRICH MESSLER</b>		4. DATE OF DEATH Month Day Year <b>MAY 6 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 9 - 1888</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS U MESSLER</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE ROWE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-22-9694</b>	
17. INFORMANT <b>CLARA MESSLER</b>		Address <b>UNION BRIDGE MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ischemic</b> DUE TO (c) <b>Heart</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1962</b> to <b>May 6, 1962</b> that (I) (we) last saw the deceased alive on <b>May 1, 1962</b> and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. MESSLER</b>		22b. DATE SIGNED <b>May 7, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. MESSLER, M.D.</b>		22d. ADDRESS <b>UNION BRIDGE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 8 - 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City, town, or county) (State) <b>CARROLL CO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hartzler &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>MAY 9 '62</b>	
ADDRESS <b>Union Bridge</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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Union House, 1000 West 10th St., Minneapolis, Minn.

Charles W. Messer, 1000 West 10th St., Minneapolis, Minn.

May 1930

Patricia, 1000 West 10th St., Minneapolis, Minn.

John W. Messer, 1000 West 10th St., Minneapolis, Minn.

1000 West 10th St., Minneapolis, Minn.

1000 West 10th St., Minneapolis, Minn.

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1000 West 10th St., Minneapolis, Minn.

1000 West 10th St., Minneapolis, Minn.

1000 West 10th St., Minneapolis, Minn.

05671

## CERTIFICATE OF DEATH

05666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL COUNTY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SYKESVILLE, MD.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SYKESVILLE, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 140 ARTHUR AVE.</b>				d. STREET ADDRESS <b>Box #140 ARTHUR AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>MITCHELL</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>1962</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 23, 1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FINISHER-CEMENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM E. MITCHELL</b>				14. MOTHER'S MAIDEN NAME <b>SARAH C. COLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-2885</b>		INFORMANT <b>MRS. CHARLES MITCHELL</b> Address <b>ARTHUR AVE, SYKESVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension - general</b> DUE TO <b>Atherosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silicosis - Worked in cement &amp; dust</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-2-62</b> to <b>5-17-62</b> , that I last saw the deceased alive on <b>5-16-62</b> , and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James L. Saffell</b> M.D.				DATE SIGNED <b>Reisterstown, Md. 5-18-62</b>			
PHYSICIAN'S NAME (Type) <b>James G. Saffell MD.</b>				REISTERSTOWN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/21/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Saffell</b>				ADDRESS <b>Westminster, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05672

## CERTIFICATE OF DEATH

Item 9 Film 0314 6/11/62 mh

05667

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs.1mo.28days.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>		d. STREET ADDRESS <b>2614 N. Charles Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Ethel</b>		First <b>Marie</b>		Middle <b>Mitchell</b>		Last <b>May</b>		4. DATE OF DEATH <b>May 29, 1962</b>		Month <b>May</b>		Day <b>29</b>		Year <b>1962</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 29, 1899</b>		9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife/odd jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>							
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Helen -</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Chronic obstructive pulmonary emphysema and fibrosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Schizophrenic reaction, paranoid type.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1960</b> to <b>May 29, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1962</b> , and that death occurred at <b>3:30 p.m.</b> the causes and on the date stated above.		22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE SIGNED <b>5-29-62</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>		22e. REC'D BY REGISTRAR <b>JUN 1 '62</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beverly National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Beverly, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Arma</b>		24a. ADDRESS <b>cost-4600 Liberty Hgts. Ave</b>		24b. DATE <b>JUN 1 '62</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>		24d. ADDRESS <b>cost-4600 Liberty Hgts. Ave</b>		24e. DATE <b>JUN 1 '62</b>		24f. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>		24g. ADDRESS <b>cost-4600 Liberty Hgts. Ave</b>		24h. DATE <b>JUN 1 '62</b>		24i. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>		24j. ADDRESS <b>cost-4600 Liberty Hgts. Ave</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05673

05668

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Westminster</b> c. LENGTH OF STAY IN b <b>37 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Westminster, R. D. 7</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Westminster</b> d. STREET ADDRESS <b>Westminster, R. D. 7</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gruver J. Morelock</b>		4. DATE OF DEATH Month Day Year <b>5/15/62 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10/18/1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>His own farm</b>	11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>
13. FATHER'S NAME <b>Milton Morelock</b>		14. MOTHER'S MAIDEN NAME <b>Susan Reinecker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>219-36-0290</b>	
17. INFORMANT <b>Mrs. Bertie Morelock, Westminster, Md. R.D.7</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushing injury to chest</b> <b>9/2.1</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 min (7)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Traitor accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>1145 a.m. 5/15 1962</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Westminster Carroll Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>formula</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baust Church Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Nr. Taneytown, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>MAY 17 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

1933

1933

County of \_\_\_\_\_ State of Maryland

Decedent - \_\_\_\_\_

Age - \_\_\_\_\_

Birth date, M. D. Y. \_\_\_\_\_

Residence, M. D. Y. \_\_\_\_\_

1933

Decedent

Age

Birth date

Sex

1933

1933

1933

1933

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

1933

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05669

1. PLACE OF DEATH e. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CRANBERRY RD at ROUTE 140</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>18 NEW WINDSOR RD.</b>	
3. NAME OF DECEASED (Type or print) <b>GALEN FRANKLIN MYERS</b>		4. DATE OF DEATH <b>MAY 9 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 9, 1906</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Western Md. R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carrill Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD J. MYERS</b>		14. MOTHER'S MAIDEN NAME <b>ELLA MYERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>705-12-5420</b>		16. SOCIAL SECURITY NO. <b>705-12-5420</b>	
17. INFORMANT <b>Galen F. Myers</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gumshot wound chest</b> 976X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-5/9 1962</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Route 140</b>		20f. (City or town) <b>Westminster</b>	
(County) <b>Carroll Md</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Marsh</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. MARSH</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/10/62</b>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens</b>		22d. LOCATION (City, town, or country) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR <b>J. E. Myers Jr., Westminster, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 14 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>05675</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05670</div> </div> </div> <div>Item 8 Film G313 5/23/62 JWC</div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER RD #4</b> c. LENGTH OF STAY IN b. <b>5 WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER RD #4 X</b> d. STREET ADDRESS											
<b>3. NAME OF DECEASED</b> (Type or print) <b>EARL WOODROW NONEMAKER</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>MAY 16 1962</b> Month Day Year											
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1917 NOV. 5, 1917</b> Yrs.		<b>9. AGE (In years last birthday)</b> <b>44</b> Yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>CARROLL CO. MD.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>CHESTER NONEMAKER</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>CORA Fisher</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> (If yes give year or dates of service) <b>WORLD WAR II 1943-14-8429</b>				<b>16. SOCIAL SECURITY NO.</b> <b>83-14-8429</b>				<b>17. INFORMANT</b> <b>MRS. EARL W. NONEMAKER</b> Address <b>SAME ADDRESS</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sunshot wound Head</b> <b>976 X</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Self Inflicted</b> DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <b>W. Glenn Speicher</b> <b>EXAMINER'S NAME (Type)</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>5/16/62</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>May 19 1962</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Jude's (Home) Church</b>		<b>22d. LOCATION (City, town, or country)</b> <b>Brook Rd</b>		<b>(State)</b> <b>Po Pa.</b>							
<b>23. FUNERAL DIRECTOR</b> <b>PA.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 18 '62</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05676 Item 3 Film Q314 6/5/62 iwr 05671										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural, Sykesville</b> c. LENGTH OF STAY IN b <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City (6)</b> d. STREET ADDRESS <b>5418 Rimmel Avenue</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Oberender, Harry</b> Middle <b>Henry</b> Last <b>V</b>					4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-1874</b>		9. AGE (In years last birthday) <b>88</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sign painter (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Oberender (deceased)</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Hoffman (deceased)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>5/8</b> to <b>5/22</b> , that (I) (we) last saw the deceased alive on <b>5/22</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Gertrude M. Gross, M.D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/22/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/25/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD Cem.</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. J. Ruck Inc</b>					ADDRESS <b>5305 HARFORD Rd.</b>		25a. REC'D BY REGISTRAR <b>MAY 25 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	

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1. The first part of the report deals with the general situation in the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation. It is a very detailed study of the country's economy. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economy.

3. The third part of the report deals with the social situation. It is a very detailed study of the country's society. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's society.

4. The fourth part of the report deals with the political situation. It is a very detailed study of the country's politics. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's politics.

5. The fifth part of the report deals with the cultural situation. It is a very detailed study of the country's culture. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's culture.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05677

05672

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>1 mo. 26 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> <b>2103-2</b> d. STREET ADDRESS <b>278 S. Prospect St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Philip Leo Reardon</b>				4. DATE OF DEATH <b>May 28, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 27, 1889</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sup't., Insurance Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Reardon</b>				14. MOTHER'S MAIDEN NAME <b>Julia McMannis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Recurrent C.V.A.</b> (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1962, to May 28, 1962</b> that (I) (we) last saw the deceased alive on <b>May 28, 1962</b> , and that death occurred <b>10:30PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Adnan Sonmez, M.D.</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/29/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Adnan Sonmez, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6-1-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SUPER-ROUZER FUNERAL HOME</b> ADDRESS <b>HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR <b>ATN</b> <b>4 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knap</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05678

CERTIFICATE OF DEATH

05673

Items 2 & 8 Film G312 5/14/62 mh

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>10 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>New Jersey</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>39 Third St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rodgers, Sadie Dorothy Raymond</u> First Middle Last 4. SEX <u>Female</u> 5. COLOR OR RACE <u>White</u> 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH <u>7/27/71</u> 8. AGE (In years last birthday) <u>90</u> yrs. 9. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Mass., U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Bernard Raymond</u> 14. MOTHER'S MAIDEN NAME <u>Sophia Raymond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>Hosp. records</u> 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>C.B.S. ass. with cerebral arteriosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7/3/61</u> to <u>5/4/62</u> , that (I) (we) last saw the deceased alive on <u>5/4/62</u> , and that death occurred at <u>5/4/62</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Agustine del Campo</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Agustine del Campo</u>		22b. DATE SIGNED <u>5/5/62</u> 22d. ADDRESS <u>Springfield State Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>5/7/1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fes</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther Knight</u> ADDRESS <u>Sykesville, Md.</u> 25a. REC'D BY REGISTRAR <u>MAY 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

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CERTIFICATE OF TITLE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05679 CERTIFICATE OF DEATH 05674											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN b. <u>7yrs 5 Mon.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2921 Kirk Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>(First Middle Last) HENRY ANDREW ROHRBACH (Jr.) Henry Andrew Rohrbach</u>					4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1962</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1892</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grand - Post Office</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Frederick Rohrbach</u>					14. MOTHER'S MAIDEN NAME <u>Mary Schwicker</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War I</u>					16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Henry Rohrbach, Jr.</u> Address <u>6013 Belle Vista Ave. Balto., Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>(Involutional psychotic reaction, plus parkinsonism)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Decubitus ulcer, multiple</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u> <u>Yrs.</u> <u>about 7 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>60</u> , to <u>May</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>May 20</u> , 19 <u>62</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Yasuo Takahashi</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>May 20, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>YASUO TAKAHASHI</u>					22d. ADDRESS <u>SPRINGFIELD STATE HOSPITAL, MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 23, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>WOODLAWN MARYLAND</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</u>					25a. REC'D BY REGISTRAR <u>MAY 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				

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CONTINUATION OF 2-10-10

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

05680

CERTIFICATE OF DEATH

05675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #1-Box 298-Liberty Road</u>				d. STREET ADDRESS <u>RFD #1-Box 298-Liberty Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>H.</u> Last <u>Rohm</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1880</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heating Contractor (self)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Rohm</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hutzler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-9557</u>		INFORMANT Address <u>Mrs. Elsie M. Rohm-RFD #1-Box 298-Liberty Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Senile Changes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>1935</u> , 19 <u>  </u> , to <u>15 May, 1962</u> , that I last saw the deceased alive on <u>15 May, 1962</u> , 19 <u>  </u> , and that death occurred at <u>6:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 54 RFD #2, Sykesville, Md</u> DATE SIGNED <u>5/15/62</u>							
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr., M.D.</u>		M.D. <u>Box 54 RFD #2, Sykesville, Md</u>					
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Jackson &amp; Sons</u>				ADDRESS <u>4700 Ave. Belts, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 16 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

AS U N 21111





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

1. PLACE OF DEATH a. COUNTY <u>Canall</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> c. LENGTH OF STAY IN b. <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Canall</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROSEMARY - A - RUBY</u> First Middle Last		4. DATE OF DEATH <u>May 14 - 1962</u> Month Day Year	
5. SEX <u>FF</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 23 - 1932</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Operator Sew Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Patrick Brady</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-28-6129</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound of chest.</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		17. INFORMANT <u>Russell Ruby</u> Address <u>Hampstead Md</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted gun shot wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5/14/62</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Hampstead</u> (County) <u>Canall</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>5/14/62</u>			
ACTUAL SIGNATURE <u>JAMES T. MARSH</u> EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		DATE SIGNED <u>5/14/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 17/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Garden</u>		22d. LOCATION (City, town, or country) <u>Canall Co Md</u>	
24a. REC'D BY REGISTRAR <u>Hampton-Elise</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Turner</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of New York, County of \_\_\_\_\_  
I, \_\_\_\_\_, Medical Examiner, do hereby certify that \_\_\_\_\_  
aged \_\_\_\_\_ years, of the County of \_\_\_\_\_ and State of \_\_\_\_\_  
died on the \_\_\_\_\_ day of \_\_\_\_\_ 1887, at \_\_\_\_\_  
\_\_\_\_\_.

Caused by \_\_\_\_\_  
\_\_\_\_\_.

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_ 1887.  
\_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 1887.  
\_\_\_\_\_

Notary Public for the State of New York.

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05682

05677

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Bridge</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salvici Run</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA PAULINE SCHAEFFER</u>		4. DATE OF DEATH Month Day Year <u>MAY 28 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13 1891</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Un-employed</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Salvici Run Md.</u>	
11c. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Schaeffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Feiser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>???</u>	
17. INFORMANT <u>Mrs. Ther. F. Brown</u>		Address <u>Penna. Ave. Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>? 4 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/27/62</u> 19____, to <u>5/28/62</u> 19____, that (I) (we) last saw the deceased alive on <u>5/28/62</u> 19____, and that death occurred at <u>6A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Caricofa</u> M.D.		22b. DATE SIGNED <u>5/28/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Bridge, Md.</u>		22d. ADDRESS <u>Wm. Bridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/31/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		25. REGISTRAR'S SIGNATURE <u>Charles S. Kane</u>	
25a. REC'D BY REGISTRAR <u>MAY 31 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kane</u>	

1891

CERTIFICATE OF DEATH

1891

CHARLES W. WILSON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05683

CERTIFICATE OF DEATH

05678

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore #2h</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>20 S. Ellwood Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Karl</u> Middle <u>Ludwig</u> Last <u>SCHARPF</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>19</u> Year <u>19 62</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u>		IF UNDER 24 HRS. Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Koester's Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>? Scharpf</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-10-6699</u>		17. INFORMANT <u>Springfield State Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive heart failure = } Bronchopneumonia, recurrent }</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>A.S.C. V.D.</u> (c) <u>A.S.C. V.D.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. &amp; Senile brain disease &amp; psychotic reaction</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-7-61</u> , 19 <u>61</u> , to <u>5/19</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>5/19/62</u> , 19 <u>62</u> , and that death occurred at <u>9</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>Adnon Sonmez, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Adnon Sonmez, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran 3000 E. Baltimore St</u>				25a. REC'D BY REGISTRAR <u>MAY 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

1961

ESTIMATE OF DAMAGE

68839

M

X

1961-1962



FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

05684

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05679

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JACKIE-LEE-SCHOONOVER</u>				4. DATE OF DEATH <u>May 19 1962</u>			
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-21-1955</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Richard Schoonover</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT Address <u>Richard Schoonover-Hampstead Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>10:30 a.m. 5/19 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cascade Ave</u>		20f. (City or town) (County) (State) <u>HAMPSTEAD CARROLL MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Johnsville Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Hiederick Co Md</u>	
23. FUNERAL DIRECTOR <u>Tipton-Eline Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

06

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*Journal of Management Education*

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
05685 CERTIFICATE OF DEATH 05680																			
Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>59 WASHINGTON, RD.</u>					d. STREET ADDRESS <u>59 WASHINGTON ROAD</u>														
3. NAME OF DECEASED (Type or print) <u>JOSEPH BERNARD SHAEFFER</u>					4. DATE OF DEATH <u>MAY 31 1962</u>														
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 16, 1898</u>		9. AGE (In years last birthday) <u>64</u> yrs.											
						IF UNDER 1 YEAR		IF UNDER 24 HRS.											
						Months		Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALES ENGINEER</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>KAUSTINE CO</u>					11. BIRTHPLACE (State or foreign country) <u>PERRY, N. WESTMINSTER, MD U.S.A.</u>									
13. FATHER'S NAME <u>HARRY K. SHAEFFER</u>					14. MOTHER'S MAIDEN NAME <u>MARY S. ECKENRODE</u>					12. CITIZEN OF WHAT COUNTRY?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					16. SOCIAL SECURITY NO. <u>216-05-4396</u>					INFORMANT <u>MRS. ADELINE T. SHAEFFER</u> Address <u>SAME ADDRESS</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CA of BLADDER and LUNGS.</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CA. of RECTUM</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u> <u>2 yrs +</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
					20f. (City or town) (County) (State)														
21. I certify that I attended the deceased from <u>MAR 1 - 1962</u> , to <u>MAY 31 1962</u> , that I last saw the deceased alive on <u>MAY 31 1962</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>105 E Main St. Westminster Md</u>					DATE SIGNED <u>6-1-62</u>				
ACTUAL SIGNATURE <u>James J. Marsh</u>					M.D. <u>—</u>														
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>6/4/62</u>					22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY RURAL, WESTMINSTER, MD</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>					ADDRESS <u>—</u>					24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 4 '62</u>									
										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>									

MD

IN 30AM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05686

## CERTIFICATE OF DEATH

05681

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>6 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Grand View Home</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Chatsworth Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Harry</b> Middle <b>H.</b> Last <b>Shaffer</b>			<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>17</b> , Year <b>1962</b> <b>19</b>		
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OF RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>Oct. 13, 1877</b> <b>9. AGE</b> (In years last birthday) <b>84</b> yrs. <b>IF UNDER 1 YEAR</b> Months <b>Days</b> <b>IF UNDER 24 HRS.</b> Hours <b>Min.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		
<b>13. FATHER'S NAME</b> <b>John D. Shaffer</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Lydia E. Arbaugh</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>212-32-4434</b> <b>17. INFORMANT</b> <b>H. Stewart Shaffer, Reisterstown, Md.</b> Address		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, arteriosclerotic heart dis., arteriosclerosis gen.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Alcohol -</b> DUE TO (c) <b>Alcohol -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <b>1956</b> <b>17 May 62</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>			<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1956</b> <b>19</b> <b>to</b> <b>17 May</b> <b>1962</b> <b>18 May 62</b> <b>that (I) (we) last saw the deceased alive on</b> <b>17 May 62</b> <b>and that death occurred at</b> <b>5:00 P.M.</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Stewart E. Hall</b> <b>M.D.</b>			<b>22b. DATE SIGNED</b> <b>18 May 62</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type)			<b>22d. ADDRESS</b> <b>Jeffersville, Md</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>May 21, 1962</b>		
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Kriders</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>Westminster, Md.</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			<b>25a. REC'D BY REGISTRAR</b> <b>MAY 21 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05687

CERTIFICATE OF DEATH

05682

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> c. LENGTH OF STAY IN 1b <b>YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11 WARD AVE</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 WESTMINSTER</b> d. STREET ADDRESS <b>11 WARD AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CECELIA ELIZABETH SKINNER</b>				4. DATE OF DEATH <b>MAY 18 1962</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 29-1893</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>HENRY C DANNER</b>				14. MOTHER'S MAIDEN NAME <b>CORA SMITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>339-07-9576</b>		17. INFORMANT <b>RURAL MRS MONROE HYDE NEW WINDSOR MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Coronary Occlusion</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular disease</b> (c) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955 May 18</b> to <b>1962 May 12</b> ; that (I) (we) last saw the deceased alive on <b>May 12 1962</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James J Marsh</b> 22b. PHYSICIAN'S NAME (Type) <b>JAMES T MARSH</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Westminster Md</b>		22b. DATE SIGNED <b>5-18-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WINTERS</b>		23d. LOCATION (City, town or county) (State) <b>NEW WINDSOR RURAL MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W D Hartzler &amp; Sons</b>				ADDRESS <b>New Windsor</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 22 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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DEPT OF DEATH

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WESTMINSTER

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11 WARD AVE

CECEILIA EMMETT SMITH

CECEILIA EMMETT SMITH

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W

HOUSE WIFE OWN HOME

HOUSE WIFE OWN HOME

HENRY C BAKER

BORN SMITH

337-07 1ST WARD

337-07 1ST WARD

Born 2/12/12

Born 2/12/12

11 WARD AVE

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05683

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL COUNTY GEN. HOSP.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MAY STAMBAUGH</u>		4. DATE OF DEATH Month Day Year <u>MAY 1 - 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV 2 - 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>W. NELSON WILKIE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARENE GRAHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>W. E. STAMBAUGH UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>42011</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic C.V. disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/29/62</u> to <u>5/1/62</u> , that (I) (we) last saw the deceased alive on <u>4/30/62</u> 19 <u>62</u> , and that death occurred at <u>1:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Marsh</u>		22b. ADDRESS <u>Union Bridge</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. MARSH</u>		22d. ADDRESS <u>Union Bridge</u>	
22e. PHYSICIAN'S SIGNATURE <u>James H. Marsh</u>		22f. ADDRESS <u>Union Bridge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>UNITED BROTHERS</u>		23d. LOCATION (City, town, or county) (State) <u>THURMONT, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hines</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 7 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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EXTRACT OF DEATH

DEEDS

PARSONS

WESTMINSTER

WESTMINSTER 2 DAYS UNION EXHIBIT

GENERAL COUNTY GEN 402 R

1914 MAY 27

NOV 2-1892

WILL BE DEED AT HOME MARYLAND

WILLIAM WIFE HIDE WARDEN

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VS. A15ME  
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

056889 of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05684

1. PLACE OF DEATH a. COUNTY <b>CARROLL CO.</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAMBER, MD.</b> c. LENGTH OF STAY IN b <b>11 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>AT FORD'S STORE, GAMBER, MD.</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAMBER, MD.</b> d. STREET ADDRESS <b>FINKSBURG RD #1, MD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK JOSEPH STECK</b>			4. DATE OF DEATH Month Day Year <b>MAY 23 1962</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/11/1914</b>		9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOSEPH STECK</b>			14. MOTHER'S MAIDEN NAME <b>BALBINA TOMCIUK</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>215-03-2709</b>		
17. INFORMANT Address <b>FINKSBURG</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James G. Saffell</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DATE SIGNED <b>MAY 23-1962</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/26/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PROVIDENCE CEMETERY</b>	
22d. LOCATION (City, town, or country) <b>GAMBER, MD.</b>		23. FUNERAL DIRECTOR <b>James G. Saffell</b>		24a. REC'D BY REGISTRAR <b>MAY 28 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		24c. ADDRESS <b>254 E. MAIN ST. WESTMINSTER, MD.</b>			

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W. H. I. 20-30-72



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FOR STATE  
HEALTH DEPT  
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TO DE. BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05690											
05685											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN b <u>2 mo +</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. Gen. Hospt.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> <u>27</u> d. STREET ADDRESS <u>70 Liberty St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH STOECKER</u> First Middle Last						4. DATE OF DEATH <u>MAY 28 1962</u> Month Day Year					
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28 1869</u> yrs.		9. AGE (In years last birthday) <u>93</u> Months Days Hours Min.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Westminster Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob T. Thomson</u>						14. MOTHER'S MAIDEN NAME <u>Mary?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. John Case, Same address</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardiac muscular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right hip</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>X</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bedroom</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3-1</u> 19 <u>62</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>5/28/62</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/31/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or country) <u>Westminster, Md.</u> (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u>MAY 31 '62</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>			
23. FUNERAL DIRECTOR <u>J. E. Myers, Jr. / Westminster, Md.</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05686

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yr. 3mo. 6da.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		1536-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>10515 Meredith Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anne</b> Middle <b>Lurie</b> Last <b>STOLZENBACH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-81</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fairweather</b>		14. MOTHER'S MAIDEN NAME <b>Genevieve Densmore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Block</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS with Circulatory Disturbance, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>1-28</b> <b>1960</b> to <b>5-4</b> <b>1962</b> , that (b) (we) last saw the deceased alive on <b>5-4</b> <b>1962</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ilse Kamm, M. D.</b>		22b. DATE SIGNED <b>5-4-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M. D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5/7/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>See Funeral Home Wash DC</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24a. FUNERAL DIRECTOR'S SIGNATURE <b>See Funeral Home Wash DC</b>		24b. ADDRESS <b>300 - H St</b>	
25a. REC'D BY REGISTRAR <b>MAY 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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CERTIFICATE OF DEATH

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(M)

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05692

## CERTIFICATE OF DEATH

05687

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>11 mo. 2dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 1</b> d. STREET ADDRESS <b>1818 N. Charles St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith Irene Trail</b>			4. DATE OF DEATH Month Day Year <b>May 25, 1962</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	
8. DATE OF BIRTH <b>December 20, 1883</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>James H. Collette</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Irwin</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT <b>Springfield Hospital records.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Severe coronary arteriosclerosis</b> DUE TO (c) <b>Pulmonary edema and early bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. with senile brain disease with psychotic reaction.</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Days</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>June 23, 1961, to May 25, 1962</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1961</b> , to <b>May 25, 1962</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1962</b> , and that death occurred at <b>4:50 a.m.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Agustin del Campo, M.D.</b>					
22b. DATE SIGNED <b>5-25-62</b>					
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>					
22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-28-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Hampden</b>	
23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		23e. (State) <b>Maryland</b>		23f. (Country) <b>U.S.A.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tucker &amp; Sons</b>					
25a. REC'D BY REGISTRAR <b>DATE MAY 28 '62</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>					

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UNITED STATES DEPARTMENT OF AGRICULTURE

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05693

## CERTIFICATE OF DEATH

05688

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN lb <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll County General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b> d. STREET ADDRESS <b>Westminster, Md. R. D. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ida Louise Utz</b>			4. DATE OF DEATH Month Day Year <b>May 6 1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/1872</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Josiah Marsh</b>			
14. MOTHER'S MAIDEN NAME <b>Leanna Wisner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Levi S. Utz, Westminster, Md. R. D. 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rectal Bleeding</b> <b>154X</b> DUE TO <b>Carcinoma of rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> <b>1962</b> to <b>5/6</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>5/6</b> <b>1962</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Julius Chopko</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/6/62</b>
22c. PHYSICIAN'S NAME (Type) <b>JULIUS CHEPKO M.D.</b>			22d. ADDRESS <b>85 1/2 W. GREEN ST. WESTMINSTER, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/8/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	
23d. LOCATION (City, town or county) <b>Silver Run, Carroll Co., Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b> ADDRESS <b>Littlestown, Pa.</b>			25a. REC'D BY REGISTRAR <b>MAY 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTHDIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05689

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster RD.</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>✓</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OTTILIE - C - VAN FLEET</u> First Middle Last 4. DATE OF DEATH <u>May 1</u> 19 <u>62</u> Month Day Year		5. SEX <u>♀</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Jan 1 - 1893</u> 9. AGE (In years) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>158-16-3816A</u> 17. INFORMANT <u>Wm P. Van Fleet</u> Address <u>Seattle - Wash</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 420.0 DUE TO <u>Arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 55</u> to <u>5-1</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-29</u> 19 <u>62</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M.C. Porterfield</u> M.D.		22b. DATE SIGNED <u>5-3-1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.C. PORTERFIELD</u>		22d. ADDRESS <u>HAMPSTEAD, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 762</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clifton - Blue</u> ADDRESS <u>Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 7 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hawk</u>	

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24c. REC'D BY REGISTRAR MAY 23 '62	24b. REGISTRAR'S SIGNATURE Arthur L. Krass
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Age: \_\_\_\_\_

3. Sex: \_\_\_\_\_

4. Date of Death: \_\_\_\_\_

5. Place of Death: \_\_\_\_\_

6. Cause of Death: \_\_\_\_\_

7. Manner of Death: \_\_\_\_\_

8. Signature of Medical Examiner: \_\_\_\_\_

9. Date of Examination: \_\_\_\_\_

10. Name of Hospital: \_\_\_\_\_

11. Name of Physician: \_\_\_\_\_

12. Name of Nurse: \_\_\_\_\_

13. Name of Coroner: \_\_\_\_\_

14. Name of Jury: \_\_\_\_\_

15. Name of Witness: \_\_\_\_\_

16. Name of Officer: \_\_\_\_\_

17. Name of Agent: \_\_\_\_\_

18. Name of Clerk: \_\_\_\_\_

19. Name of Stenographer: \_\_\_\_\_

20. Name of Interpreter: \_\_\_\_\_

21. Name of Translator: \_\_\_\_\_

22. Name of Recorder: \_\_\_\_\_

23. Name of Secretary: \_\_\_\_\_

24. Name of Assistant: \_\_\_\_\_

25. Name of Aide: \_\_\_\_\_

26. Name of Attendant: \_\_\_\_\_

27. Name of Caretaker: \_\_\_\_\_

28. Name of Custodian: \_\_\_\_\_

29. Name of Keeper: \_\_\_\_\_

30. Name of Guard: \_\_\_\_\_

31. Name of Patrolman: \_\_\_\_\_

32. Name of Watchman: \_\_\_\_\_

33. Name of Sentry: \_\_\_\_\_

34. Name of Soldier: \_\_\_\_\_

35. Name of Sailor: \_\_\_\_\_

36. Name of Marine: \_\_\_\_\_

37. Name of Pilot: \_\_\_\_\_

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39. Name of Lieutenant: \_\_\_\_\_

40. Name of Sergeant: \_\_\_\_\_

41. Name of Corporal: \_\_\_\_\_

42. Name of Private: \_\_\_\_\_

43. Name of Gunner: \_\_\_\_\_

44. Name of Engineer: \_\_\_\_\_

45. Name of Mechanic: \_\_\_\_\_

46. Name of Electrician: \_\_\_\_\_

47. Name of Plumber: \_\_\_\_\_

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4y. 5m. 3d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuscarora</b> <b>10X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>--</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>May</b> Last <b>Wenner</b>			4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1962</b>						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/5/89</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Chick</b>					14. MOTHER'S MAIDEN NAME <b>Barnhouse</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Springfield Hospital records - Sykesville, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the cervix</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General metastasis</b> DUE TO (c) <b>Cardiac failure</b>									INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>months</b> <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>12/19/</b> 19 <b>57</b> , to <b>5/22/</b> 19 <b>62</b> , that <b>AS</b> (we) last saw the deceased alive on <b>5/22/</b> 19 <b>62</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Naci N. Buyukunsal</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/22/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-24-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Pleasant</b>		23d. LOCATION (City, town, or county) (State) <b>TAYLORSTOWN VA.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Flete Funeral Home</b>					ADDRESS <b>Brownsville mo.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 24 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. F...</b>

